

UNICARE STATE INDEMNITY PLAN/ COMMUNITY CHOICE

Benefit Updates and Important Information
For Active Employees and
Non-Medicare-Eligible Retirees

Effective February 1, 2010

Updates to the UniCare State Indemnity Plan/Community Choice Member Handbook

This *Benefit Updates and Plan Information* booklet (“Benefit Update”) contains important updates to your UniCare State Indemnity Plan/Community Choice coverage, effective February 1, 2010. Please keep this Benefit Update—together with the Series 5 Member Handbook (“Member Handbook”) and 2009 Benefit Update—in a convenient place for easy access when you need to check your health plan information.

This Benefit Update is also available on the Plan’s website: visit **www.unicarestatplan.com** > “Members” > “Forms and Documents.” The updates in this Benefit Update will also be incorporated into the next printed version of your Member Handbook.

If you have any questions about these changes, please call UniCare Customer Service at (800) 442-9300, Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. You can also e-mail us from our website: **www.unicarestatplan.com** (click on “Contact Us”). If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at (800) 322-9161 or (978) 474-5163. A UniCare customer service representative will be happy to help you.

Note: Page references in this Benefit Update refer to pages in your Member Handbook unless otherwise indicated.

Calendar Year Deductible

Beginning February 1, 2010, you must meet a calendar year deductible for most covered services before your health plan begins paying benefits for you or your dependent(s). The calendar year deductible is \$250 per member and \$750 per family. The calendar year deductible amounts you must satisfy are shown in the chart on page 4 of this Benefit Update.

The following changes are made to your Member Handbook to reflect this change:

- A. The “Deductibles” subsection on pages 7-8 in the “Your Costs” section of your Member Handbook, and the deductibles chart on page 2 of your 2009 Benefit Update, are deleted and replaced with the text below. This subsection has been renamed, “Calendar Year Deductible.”

Note: Information about the inpatient hospital deductible and the outpatient surgery deductible is deleted from the “Deductibles” subsection and added to the updated “Copayments” subsection on pages 12-15 of this Benefit Update. These amounts are now referred to as copays rather than deductibles.

Calendar Year Deductible

The calendar year deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or for a covered dependent. The calendar year deductible amounts you must satisfy are shown in the chart on page 4 of this Benefit Update.

Individual Calendar Year Deductible

The individual calendar year deductible is the amount you must pay before benefits for many services begin for that calendar year. In addition to meeting the individual calendar year deductible, you continue to be responsible for copays and coinsurance amounts, where applicable. For updated copay amounts, see the charts on pages 14-15 of this Benefit Update.

Example: If you go to a provider for a medical problem in January, you will have to pay the applicable copay and then \$250 of the Allowed Amount. If your provider charges less than \$250, the balance of the deductible will be taken from your next service. If there are remaining charges after the deductible, then, depending on the service provided, the Plan pays either 100% of the Allowed Amount, or 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the \$250 calendar year deductible, you will not have to pay it again for the remainder of the calendar year for any services you receive.

The Plan determines the providers to whom you owe the deductible based on the order in which the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe deductible amounts for any services you receive.

The calendar year deductible applies to most medical services you receive. Check the Summary of Covered Services charts on pages 5-11 of this Benefit Update to see the services to which the calendar year deductible applies.

Benefit Changes & Clarifications

Family Calendar Year Deductible

If you have family coverage, a deductible will apply to your family in any calendar year. The family calendar year deductible is a maximum dollar amount your family must pay before benefits for many services begin for that calendar year. In addition to meeting the family calendar year deductible, you and your dependent(s) continue to be responsible for copays and coinsurance amounts, where applicable. For updated copay amounts, see the charts on pages 14-15 of this Benefit Update.

The maximum each person in the family must satisfy is \$250 until the family as a whole reaches the \$750 maximum.





Example: You, your spouse and your three children have family coverage under the Community Choice Plan. You and your three children go to providers for medical care in January. Three of you pay \$200 deductibles and one of you pays a \$150 deductible. Even though no individual family member has met the \$250 deductible, the family deductible of \$750 has been met. Therefore, no additional calendar year deductible will apply to your family for that calendar year.


Calendar Year Deductible	When you use any provider
Individual Calendar Year Deductible	\$250 per calendar year
Family Calendar Year Deductible	\$750 per calendar year If you have family coverage, \$750 in deductibles will apply to your family in any calendar year. The deductible for any individual family member will not exceed \$250.

Benefit Changes & Clarifications

- B. The Summary of Covered Services charts in the “Benefit Highlights” section on pages 28-34 of your Member Handbook, and on pages 5 and 6 of your 2009 Benefit Update, are deleted and replaced with the following charts. **Note:** The page references in the third column of these charts, as well as the page references to appendices elsewhere in these charts, refer to pages in your Member Handbook, unless otherwise indicated.



Summary of Covered Hospital-Based Services



Community Choice Hospitals		Other Hospitals
 Inpatient Hospital Services in an Acute Medical, Surgical or Rehabilitation Facility		 Also see page 35
Semi-Private Room, ICU, CCU and Ancillary Services	100% after the inpatient hospital quarterly copay and after the calendar year deductible	100% after the inpatient hospital copay per admission and after the calendar year deductible
Medically Necessary Private Room	100% for the first 90 days in a calendar year after the inpatient hospital quarterly copay and after the calendar year deductible; then 100% at the semi-private level	100% for the first 90 days in a calendar year after the inpatient hospital copay per admission and after the calendar year deductible; then 100% at the semi-private level
Inpatient Diagnostic Laboratory and Radiology (including high-tech imaging)	100% after the calendar year deductible	100% after the calendar year deductible
 Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs (See Appendix D for list of procedures and hospitals.)		 Also see page 51
Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs	100% after the inpatient hospital quarterly copay and after the calendar year deductible at a Designated Hospital or Community Choice Hospital	100% after the inpatient hospital copay per admission and after the calendar year deductible


 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the “Managed Care Program” section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Hospital-Based Services






Quality Centers and Designated Hospitals for Transplants		Other Hospitals
 Transplant Services		 Also see page 42
	100% after the inpatient hospital quarterly copay, and after the calendar year deductible	<p>At a Community Choice Hospital: 80% after the inpatient hospital quarterly copay and after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.</p> <p>At a Non-Community Choice Hospital: 80% after the inpatient hospital copay per admission and after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.</p>

Community Choice Hospitals		Other Hospitals
Other Inpatient Facilities		 Also see page 35
<ul style="list-style-type: none"> ▪ Sub-Acute Care Hospitals/Facilities ▪ Transitional Care Hospitals/Facilities ▪ Long-Term Care Hospitals/Facilities ▪ Chronic Disease Hospitals/Facilities ▪ Skilled Nursing Facilities 	80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after the calendar year deductible, up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Coronary Artery Disease (CAD) Secondary Prevention Program		 Also see page 25
Designated Programs Available through Medical Case Management	90% after the calendar year deductible. The 10% coinsurance amount does not count toward the out-of-pocket maximum.	90% after the calendar year deductible. The 10% coinsurance amount does not count toward the out-of-pocket maximum.
All Other Programs	Not covered	Not covered


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For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Hospital-Based Services








	Community Choice Hospitals	Other Hospitals
Outpatient Hospital Services		 Also see pages 36-41
Emergency Room Charge	100% after the emergency room copay and after the calendar year deductible; copay waived if admitted	100% after the emergency room copay and after the calendar year deductible; copay waived if admitted
Diagnostic Laboratory Testing	100% after the calendar year deductible	100% after the outpatient lab copay and after the calendar year deductible ¹
High-Tech Imaging (such as MRIs, CT scans and PET scans) as Part of an Emergency Room Treatment	100% after the calendar year deductible	100% after the calendar year deductible
 All Other High-Tech Imaging (such as MRIs, CT scans and PET scans)	100% after the high-tech imaging copay per scan and after the calendar year deductible; maximum of one copay per day	100% after the high-tech imaging copay per scan and after the calendar year deductible; maximum of one copay per day
All Other Radiology	100% after the calendar year deductible	100% after outpatient radiology copay and after the calendar year deductible; maximum of one copay per day ¹
 Surgery	100% after the outpatient surgery quarterly copay and after the calendar year deductible	100%, after the outpatient surgery copay per occurrence and after the calendar year deductible
 Physical Therapy and  Occupational Therapy	100% after the copay	100% after the copay
Speech Therapy	100%, up to a maximum benefit of \$2,000 per calendar year	100%, up to a maximum benefit of \$2,000 per calendar year
Chemotherapy	100% after the calendar year deductible	100% after the calendar year deductible
Other Outpatient Hospital Services	100% after the calendar year deductible	100% after the calendar year deductible

¹ If you receive both laboratory and x-ray services at a non-Community Choice hospital in the same day, you will only be responsible for one copay.


 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Non-Hospital-Based Services










All Providers	
Physician Services	 Also see page 40
Inpatient	100% after the calendar year deductible
Emergency Room Treatment	100% after the calendar year deductible
Office, Home or Outpatient Hospital	100% after the applicable office visit copay
 Surgery at an Ambulatory Surgical Facility or Physician's Office	100% after the calendar year deductible
 Chiropractic Care or Treatment	80% after the chiropractic visit copay; maximum benefit of \$40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
 Physical Therapy and  Occupational Therapy	 Also see page 40
	100% after the copay
Preventive Care For information on covered preventive laboratory services and for office visit frequency limits, see pages 40-41.	 Also see pages 40-41
Office Visits	100% after the applicable office visit copay
Annual Gynecological Visits	100% after the applicable office visit copay
Immunizations	100%
Colonoscopies ¹	100% after the outpatient surgery copay
Mammograms ¹	100%
Pap Smears ¹	100%
Bone Density Testing	100% after the calendar year deductible
Covered Laboratory Testing	100% after the calendar year deductible

¹ Colonoscopies, mammograms and Pap smears are subject to the calendar year deductible when performed for diagnostic (non-preventive) treatment.


 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.


For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Non-Hospital-Based Services

All Providers	
Licensed Retail Medical Clinics at Retail Pharmacies	 Also see page 7 of your 2009 Benefit Update
	100% after the copay
Family Planning Services	 Also see page 38
Office Visits	100% after the applicable office visit copay
Procedures	100% after the calendar year deductible
Diagnostic Laboratory Tests (non-hospital based)	 Also see pages 39-40
	100% after the calendar year deductible
 Radiology (non-hospital based)	 Also see page 41
High-Tech Imaging (such as MRIs, CT scans and PET scans)	100% after the high-tech imaging copay per scan and after the calendar year deductible; maximum of one copay per day ¹
All Other Radiology	100% after the calendar year deductible
 Private Duty Nursing	 Also see page 41
Provided in a Home Setting Only	80% after the calendar year deductible for a registered nurse, up to a calendar year maximum benefit of \$8,000. Of this \$8,000, up to \$4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
 Home Health Care	 Also see page 38
Medicare Certified Home Health Agencies and Visiting Nurse Associations ²	80% after the calendar year deductible








¹ If you receive both laboratory and x-ray services at a non-Community Choice hospital in the same day, you will only be responsible for one copay.


² A program is available to enhance the benefit for home health care by using designated providers.  Check our list of Preferred Vendors at www.unicarestateplan.com > "Find a Provider" > "All Provider Listings," or call the Andover Service Center at (800) 442-9300 for more information.

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.


For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Non-Hospital-Based Services

All Providers	
 Home Infusion Therapy	 Also see page 52
Preferred Vendors ¹	100% after the calendar year deductible
Other Vendors	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Hospice	 Also see page 42
Medicare Certified Hospice	100% after the calendar year deductible
Bereavement Counseling	80% after the calendar year deductible, up to a maximum benefit of \$1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Early Intervention Services for Children	 Also see page 38
Programs Approved by the Department of Public Health	80% after the calendar year deductible, up to a maximum benefit of \$5,200 per child per calendar year, and a lifetime maximum benefit of \$15,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Ambulance	 Also see pages 37, 48
	100% after the calendar year deductible
 Durable Medical Equipment	 Also see page 43
Preferred Vendors ^{1,2}	100% after the calendar year deductible
Other Vendors	80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.







¹  For a list of the Plan's Preferred Vendors, go to www.unicarestateplan.com > "Find a Provider" > "All Provider Listings," or call the Andover Service Center at (800) 442-9300.

² If an item is not available through a Preferred Vendor and you obtain it from another provider, it will be covered at 80%.

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Non-Hospital-Based Services

All Providers	
Hospital-Based Personal Emergency Response Systems (PERS)	 Also see page 43
Installation	80% after the calendar year deductible, up to a maximum benefit of \$50. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Rental Fee	80% after the calendar year deductible, up to a maximum benefit of \$40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Prostheses¹	 Also see page 41
	80% after the calendar year deductible
Braces²	 Also see page 37
	80% after the calendar year deductible
Hearing Aids	 Also see page 38
	100% of the first \$500; then 80% of the next \$1,500, up to a maximum of \$1,700 every two years. The 20% coinsurance amount does not count toward the out-of-pocket maximum.
Eyeglasses / Contact Lenses	 Also see page 49
	80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery.
Routine Eye Examinations (including refraction)	
	100% after the applicable copay. Covered once every 24 months.
All Other Covered Medical Services	 Also see pages 37-41
	80% after the calendar year deductible

¹ Breast prostheses are covered at 100% after the calendar year deductible. Wigs are not subject to the calendar year deductible.

² Orthopedic shoe(s) with attached brace is covered at 100% after the calendar year deductible.

For deductible and copay amounts, see the charts on pages 4, 14 and 15 of this Benefit Update. All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Copays for Medical Services

Copay Changes

Beginning February 1, 2010, copays for the following services are changed:

- Physician office visits
- Licensed retail medical clinics at retail pharmacies
- Services provided by nurse practitioners
- Routine eye exams
- Physical therapy and occupational therapy
- Chiropractic care
- Family planning services office visits
- Emergency room charge
- Outpatient surgery
- Outpatient high-tech imaging, such as MRIs, CT scans and PET scans

For changes to office visit copays for mental health, substance abuse and Employee Assistance Programs, see page 17 of this Benefit Update.

In addition, the inpatient hospital deductible and outpatient surgery deductible are now referred to as copays. This change is reflected in your Member Handbook as follows:

- References to these two deductibles have been removed from the “Deductibles” subsection on pages 7-8 in the “Your Costs” section of your Member Handbook and on page 2 of your 2009 Benefit Update, and added to the updated “Copayments” subsection on pages 12-15 of this Benefit Update.
- The following terms are changed as indicated below, wherever they appear in your Member Handbook:
 - “inpatient hospital deductible” is changed to “inpatient hospital copay”
 - “outpatient surgery deductible” is changed to “outpatient surgery copay”

The “Copayment” subsection on pages 8-9 in the “Your Costs” section of your Member Handbook, and the copay chart on page 3 of your 2009 Benefit Update, are deleted and replaced with the following, to reflect the above copay changes:

Copayments

A copayment (“copay”) is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the provider, the type of service you receive, the tier level of the physician, and whether you use a Community Choice Hospital or a non-Community Choice Hospital. Copays are always deducted before the individual calendar year deductible is applied (where applicable). Copays do not count toward satisfying the annual calendar year deductible, coinsurance amounts or out-of-pocket maximums. See the copay charts on pages 14-15 of this Benefit Update for copays for each type of service.

Example: If you are a member of the Community Choice Plan and you or a covered dependent go to a physician’s office, you or your dependent will be responsible for paying an office visit copay. Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

Another example of a copay you may owe is the emergency room copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital copay applies.

Inpatient Hospital Copays

You pay different copays for inpatient hospital services, depending on where you receive care, as follows. See the inpatient hospital care copay chart on page 14 of this Benefit Update.

1. **When you use a Community Choice Hospital or one of the hospitals under the circumstances specified in items 2-5 in the inpatient hospital care copay chart on page 14 of this Benefit Update,** the inpatient hospital copay applies on a per-person, per-calendar-year-quarter basis. Each time you or a covered dependent is admitted to a hospital, you are responsible for this copay. However, once a covered person pays this copay in any single calendar year quarter, he or she will not have to pay the copay again during that same calendar year quarter. In

addition, the inpatient hospital copay is waived for re-admissions that occur within 30 days following a hospital discharge, within the same calendar year (even if the admissions occur in different calendar year quarters). This copay does not apply toward the calendar year deductible.

Example 1: If you are admitted in January to any of the hospitals specified in items 1-5 in the inpatient hospital care copay chart on page 14 of this Benefit Update, and stay overnight, you will be responsible for paying the inpatient hospital copay. If you are re-admitted to one of these hospitals in March, you will not be responsible for another inpatient hospital copay, as March is in the same calendar year quarter as January. However, if you are re-admitted to one of these hospitals in May, you will incur another inpatient hospital copay.

Example 2: If you are admitted to one of these hospitals at the end of March and then re-admitted in April (within 30 days of your March discharge), you will not be responsible for another inpatient hospital copay. But if you are re-admitted to one of these hospitals in May (more than 30 days from your March discharge), you will incur another inpatient hospital copay.

Example 3: If you are admitted to one of these hospitals at the end of December and then are re-admitted in the beginning of January, you will be responsible for another inpatient hospital copay because the admissions were not in the same calendar year (even though the two admissions occur within 30 days of each other).

2. **When you use a hospital other than those specified in items 1-5 in the chart on page 14 of this Benefit Update**, the inpatient hospital copay applies on a per-person, per-admission basis. When you or a covered dependent is admitted to a hospital other than those listed in items 1-5 on page 14 of this Benefit Update, you are responsible for this copay.

Outpatient Surgery Copays

You pay different copays for outpatient surgery at a hospital, depending on where you receive care, as shown in the outpatient care copay chart on page 15 of this Benefit Update.

1. **When you use a Community Choice Hospital** – The outpatient surgery copay is a per-person, per-calendar-year-quarter copay when you have outpatient surgery at a Community Choice Hospital. Each time you or a covered dependent has surgery at a hospital, you are responsible for paying this copay. However, once a covered person pays the outpatient surgery quarterly copay in any calendar year quarter, he or she will not have to pay this copay again during that same calendar year quarter. This copay does not apply toward the calendar year deductible. (Note: When you have outpatient surgery at a freestanding ambulatory surgical facility or at a physician's office, you do not have to pay the outpatient surgery copay.)

Example: If you have outpatient surgery in January at a Community Choice Hospital, you will be responsible for paying the outpatient surgery copay at Community Choice Hospitals on the hospital charges. If you have another surgery in March, you will not have to pay another outpatient surgery copay, as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another outpatient surgery copay.

2. **When you use a non-Community Choice Hospital** – The outpatient surgery copay is a per-person, per-occurrence copay. When you or a covered dependent has surgery at one of these hospitals, you are responsible for paying this copay.

Benefit Changes & Clarifications

Copays for Medical Services


The following two charts show the copays you are responsible for with certain types of medical services. The names of the tiers have been assigned by the GIC for use uniformly across all of its health plans. For information about physician tier designations, see page 4 of your 2009 Benefit Update. (Please note that you are not required to select a primary care physician.)

You can also see the following providers at the same copay level as Tier 2 physicians:

- All non-Massachusetts physicians
- Physicians listed in the Massachusetts Physician Tier Listing with the indication that they do not have sufficient data available to allow us to determine any type of scoring—such as those physicians who are new to practice
- Nurse practitioners and physician assistants


Inpatient Hospital Care

Where You Receive Hospital Care	Inpatient Hospital Copay
<p>You pay the lowest copays when:</p> <ol style="list-style-type: none">1. You use hospitals on the updated Community Choice Hospital Listing (see “Appendix C” on pages 18-20 of this Benefit Update). Note: This listing has changed since October 2009. <p>OR</p> <p>You use non-Community Choice Hospitals in the following situations:</p> <ol style="list-style-type: none">2. You have one of the Complex Procedures listed in Appendix D performed at one of the Designated Hospitals listed in Appendix D on page 35 of your 2009 Benefit Update.3. You get admitted to any hospital through the emergency room4. You receive care at any acute rehabilitation facility, or5. You receive transplant services at any of the Quality Centers and Designated Hospitals for Transplants¹	<p>\$250 per calendar quarter. The inpatient hospital copay is waived for re-admissions that occur within 30 days following a hospital discharge, within the same calendar year.</p>
<p>You pay higher copays when: You use any hospital other than those specified above</p>	<p>\$750 per admission. The inpatient hospital copay is waived for re-admissions that occur within 30 days following a hospital discharge, within the same calendar year.</p>

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the “Managed Care Program” section for specific notification requirements and responsibilities.

¹ For more information regarding Quality Centers and Designated Hospitals for Transplants, call and speak to a UniCare case manager at (800) 442-9300.

Benefit Changes & Clarifications

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the "Managed Care Program" section for specific notification requirements and responsibilities.

Primary care physicians are pediatricians, and physicians specializing in family medicine, general medicine and/or internal medicine. Some primary care physicians may also be specialty care physicians and, if so, may be considered to be specialists in the determination of their tier and copay assignments. This means you will pay the office visit copay for the type of practice the physician has been designated to, regardless of whether you see the physician for a primary care or specialty care visit.

The subsection, “Expedited Appeals Process” in the “Managed Care Program” section on page 25 of your Member Handbook is now titled, “Reconsideration Process.”

Important Plan Information

Online Plan Resources

Online Access to Medical Information and Plan Resources at www.unicarestateplan.com

The Healthcare Advisor™, a hospital comparison resource, is no longer available at www.unicarestateplan.com. To reflect this change to your Member Handbook, the bulleted item titled, “Get help from the Healthcare Advisor™” under the subheading, “Online Access to Medical Information and Plan Resources at www.unicarestateplan.com” on page 4 of your Member Handbook, has been deleted. See our link to other hospital comparison resources on our “Health Care Quality Initiatives” page under the “Members” tab at www.unicarestateplan.com.

United Behavioral Health

Mental Health, Substance Abuse and Enrollee Assistance Programs — Effective February 1, 2010

Effective February 1, 2010, there will be changes to your copays for outpatient mental health, substance abuse and Enrollee Assistance Program (EAP) visits. The benefits charts on page 85 of your Member Handbook and on page 26 of your 2009 Benefit Update are deleted and replaced with the following to reflect this change:

Covered Services	Network Benefits	Out-of-Network Benefits
Outpatient Care (e, f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP)		
Enrollee Assistance Program (EAP)	Up to 3 visits: 100%	No coverage for EAP
	EAP <i>non-notification penalty</i> reduces benefit to zero: no benefits paid.	
Individual and Family Therapy	100%, after \$20 per visit	First 15 visits: 80% of <i>allowed charges</i> (e, f) Visits 16 and over: 50% of <i>allowed charges</i> (e, g)
Group Therapy	100%, after \$15 per visit	First 15 visits: 80% of <i>allowed charges</i> (e, f) Visits 16 and over: 50% of <i>allowed charges</i> (e, g)
Medication Management: (15-30 minute psychiatrist visit)	100%, after \$15 per visit	First 15 visits: 80% of <i>allowed charges</i> (e, f) Visits 16 and over: 50% of <i>allowed charges</i> (e, f)
In-Home Mental Health Care	Full coverage	First 15 visits: 80% of <i>allowed charges</i> (e, f) Visits 16 and over: 50% of <i>allowed charges</i> (e, f)
Drug Testing (as an adjunct to Substance Abuse treatment)	Full coverage	No coverage
	<i>Non-notification penalty</i> reduces benefit to zero: no benefits paid.	
Provider Eligibility – Provider must be licensed in one of these disciplines.	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)	MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network* and *out-of-network out-of-pocket maximums* do not *cross accumulate*.

(b) *Cross accumulates* with all *out-of-network* mental health and substance abuse benefit levels.

(c) Waived if re-admitted within 30 days: maximum one *deductible* per calendar quarter.

(d) Out-of-network care that is not preauthorized is subject to financial penalty and retrospective review.

(e) All care requires preauthorization.

(f) All *out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.

(g) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

Please note: The words in italics have special meanings that are given in the Glossary section in Part II on pages 81-82 of your Member Handbook.

Appendix C: Community Choice Hospital Listing

The Community Choice Hospital Listing has been updated to reflect the following changes:

Two hospitals are **added** to the Community Choice Hospital Listing:

- Baystate Franklin Medical Center, Greenfield
- Milton Hospital, Milton

The Community Choice Hospital Listings on pages 101-103 of your Member Handbook, and on pages 32-34 of your 2009 Benefit Update, are deleted and replaced with the following:

Community Choice Hospital Listing – Updated February 1, 2010

Athol, MA

Athol Memorial Hospital
2033 Main Street
Athol, MA 01331
(978) 249-3511

Beverly, MA

**Northeast Health System –
Beverly Hospital**
85 Herrick Street
Beverly, MA 01915
(978) 922-3000

Boston, MA

**Beth Israel Deaconess
Medical Center**
330 Brookline Avenue
Boston, MA 02215
(617) 667-7000

Caritas Carney Hospital
2100 Dorchester Avenue
Dorchester, MA 02124
(617) 296-4000

Children's Hospital Boston
300 Longwood Avenue
Boston, MA 02115
(617) 355-6000

New England Baptist Hospital
125 Parker Hill Avenue
Boston, MA 02120
(617) 754-5800

Brockton, MA

**Signature Healthcare
Brockton Hospital**
680 Center Street
Brockton, MA 02302
(508) 941-7000

**Caritas Good Samaritan
Medical Center**
235 North Pearl Street
Brockton, MA 02301
(508) 427-3000

Burlington, MA

Lahey Clinic Medical Center
41 Mall Road
Burlington, MA 01805
(781) 744-5100

Cambridge, MA

**Cambridge Health Alliance –
Cambridge Hospital**
1493 Cambridge Street
Cambridge, MA 02139
(617) 665-1000

Mount Auburn Hospital
330 Mount Auburn Street
Cambridge, MA 02138
(617) 492-3500

Clinton, MA

Clinton Hospital
201 Highland Street
Clinton, MA 01510
(978) 368-3000

Everett, MA

**Cambridge Health Alliance –
Whidden Memorial Hospital**
103 Garland Street
Everett, MA 02149
(617) 389-6270

Fall River, MA

**Southcoast Health System –
Charlton Memorial Hospital**
363 Highland Avenue
Fall River, MA 02720
(508) 679-3131

Fitchburg, MA

HealthAlliance Hospital
275 Nichols Road
Fitchburg, MA 01420
(978) 343-5000

Framingham, MA

MetroWest Medical Center
115 Lincoln Street
Framingham, MA 01701
(508) 383-1000

Appendix C: Community Choice Hospital Listing

Gardner, MA

Heywood Hospital
242 Green Street
Gardner, MA 01440
(978) 632-3420

Gloucester, MA

**Northeast Health System –
Addison Gilbert Hospital**
298 Washington Street
Gloucester, MA 01930
(978) 283-4000

Great Barrington, MA

Fairview Hospital
29 Lewis Avenue
Great Barrington, MA 01230
(413) 528-0790

Greenfield, MA

Baystate Franklin Medical Center
164 High Street
Greenfield, MA 01301
(413) 773-0211

Haverhill, MA

Merrimack Valley Hospital
140 Lincoln Avenue
Haverhill, MA 01830
(978) 374-2000

Holyoke, MA

Holyoke Medical Center
575 Beech Street
Holyoke, MA 01040
(413) 534-2500

Hyannis, MA

Cape Cod Hospital
27 Park Street
Hyannis, MA 02601
(508) 771-1800

Leominster, MA

HealthAlliance Hospital
60 Hospital Road
Leominster, MA 01453
(978) 466-2000

Lowell, MA

Saints Memorial Medical Center
One Hospital Drive
Lowell, MA 01852
(978) 458-1411

Marlborough, MA

Marlborough Hospital
157 Union Street
Marlborough, MA 01752
(508) 481-5000

Medford, MA

**Hallmark Health –
Lawrence Memorial Hospital**
170 Governors Avenue
Medford, MA 02155
(781) 306-6000

Melrose, MA

**Hallmark Health –
Melrose-Wakefield Hospital**
585 Lebanon Street
Melrose, MA 02176
(781) 979-3000

Milford, MA

Milford Regional Medical Center
14 Prospect Street
Milford, MA 01757
(508) 473-1190

Milton, MA

Milton Hospital
199 Reedsdale Road
Milton, MA 02186
(617) 696-4600

Natick, MA

MetroWest Medical Center
67 Union Street
Natick, MA 01760
(508) 650-7000

Needham, MA

Beth Israel Deaconess Hospital
148 Chestnut Street
Needham, MA 02192
(781) 453-3000

New Bedford, MA

**Southcoast Health System –
St. Luke's Hospital**
101 Page Street
New Bedford, MA 02740
(508) 997-1515

Newburyport, MA

Anna Jaques Hospital
25 Highland Avenue
Newburyport, MA 01950
(978) 463-1000

Newton, MA

Newton-Wellesley Hospital
2014 Washington Street
Newton, MA 02462
(617) 243-6000

North Adams, MA

North Adams Regional Hospital
71 Hospital Avenue
North Adams, MA 01247
(413) 663-3701

Northampton, MA

Cooley Dickinson Hospital
30 Locust Street
Northampton, MA 01061
(413) 582-2000

Appendix C: Community Choice Hospital Listing

Norwood, MA

Caritas Norwood Hospital
800 Washington Street
Norwood, MA 02062
(781) 769-4000

Palmer, MA

**Wing Memorial Hospital
& Medical Centers**
40 Wright Street
Palmer, MA 01069
(413) 284-5400

Pittsfield, MA

Berkshire Medical Center
725 North Street
Pittsfield, MA 01201
(413) 447-2000

Plymouth, MA

Jordan Hospital
275 Sandwich Street
Plymouth, MA 02360
(508) 746-2001

Quincy, MA

Quincy Medical Center
114 Whitwell Street
Quincy, MA 02169
(617) 773-6100

Somerville, MA

**Cambridge Health Alliance –
Somerville Hospital**
230 Highland Avenue
Somerville, MA 02143
(617) 591-4500

Springfield, MA

Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199
(413) 794-0000

Mercy Medical Center
271 Carew Street
Springfield, MA 01104
(413) 748-9000

Taunton, MA

**Morton Hospital &
Medical Center**
88 Washington Street
Taunton, MA 02780
(508) 828-7000

Ware, MA

Baystate Mary Lane Hospital
85 South Street
Ware, MA 01082
(413) 967-6211

Wareham, MA

**Southcoast Health System –
Tobey Hospital**
43 High Street
Wareham, MA 02571
(508) 295-0880

Westfield, MA

Noble Hospital
115 West Silver Street
Westfield, MA 01085
(413) 568-2811

Winchester, MA

Winchester Hospital
41 Highland Avenue
Winchester, MA 01890
(781) 729-9000

Worcester, MA

Saint Vincent Hospital
123 Summer Street
Worcester, MA 01608
(508) 363-5000

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